

		FOR BHF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div><div>I. IDPH Facility ID Number: 0014506</div><div>Facility Name: The United Methodist Village</div><div>Address: 1616 Cedar St Lawrenceville 62439</div><div>County: Lawrence</div><div>Telephone Number: (618) 943-3347 Fax #: (618) 943-3823</div><div>HFS ID Number: 370673519001</div><div>Date of Initial License for Current Owners: 06/01/92</div><div>Type of Ownership:</div><div><div><div><div><input checked="" type="checkbox"/> VOLUNTARY,NON-PROFIT</div><div><input checked="" type="checkbox"/> Charitable Corp.</div><div><input type="checkbox"/> Trust</div></div><div>IRS Exemption Code</div></div><div><div><input type="checkbox"/> PROPRIETARY</div><div><input type="checkbox"/> Individual</div><div><input type="checkbox"/> Partnership</div><div><input type="checkbox"/> Corporation</div><div><input type="checkbox"/> "Sub-S" Corp.</div><div><input type="checkbox"/> Limited Liability Co.</div><div><input type="checkbox"/> Trust</div><div><input type="checkbox"/> Other</div></div><div><div><input type="checkbox"/> GOVERNMENTAL</div><div><input type="checkbox"/> State</div><div><input type="checkbox"/> County</div><div><input type="checkbox"/> Other</div></div></div></div> <div><div>In the event there are further questions about this report, please contact:</div><div>Name: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div>
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SEE ACCOUNTANTS' COMPILATION REPORT

#	0014506	Report Period Beginning:	01/01/05	Ending:	12/31/05
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**D. How many bed-hold days during this year were paid by the Department?**

**None** (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.**  
(E.g., day care, "meals on wheels", outpatient therapy)

**None**

**F. Does the facility maintain a daily midnight census?** Yes

YES ☒ NO ☐

YES ☒ NO ☐

Date started 1/1/25

YES ☐ Date \_\_\_\_\_ NO ☒

YES ☒ NO ☐ If YES, enter number  
of beds certified 20 and days of care provided 3,065

**Medicare Intermediary      Mutual of Omaha**

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
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**Is your fiscal year identical to your tax year?** YES ☐ NO ☐

**\* All facilities other than governmental must report on the accrual basis.**

**C. Percent Occupancy.** (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **50.63%**

Facility Name & ID Number      The United Methodist Village      #      0014506      Report Period Beginning:      01/01/05      Ending:      12/31/05

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	290,320	15,278	11,993	317,591		317,591	(324)	317,267			1
2	Food Purchase		242,072		242,072		242,072	(82,207)	159,865			2
3	Housekeeping	179,463	31,109		210,572		210,572	(15,357)	195,215			3
4	Laundry	45,369	28,013		73,382		73,382		73,382			4
5	Heat and Other Utilities			349,144	349,144		349,144	(209,538)	139,606			5
6	Maintenance	138,715	55,989	37,703	232,407		232,407	(22,830)	209,577			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	653,867	372,461	398,840	1,425,168		1,425,168	(330,256)	1,094,912			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	1,830,400	62,937	11,705	1,905,042		1,905,042	(13,244)	1,891,798			10
10a	Therapy	94,623		1,670	96,293		96,293		96,293			10a
11	Activities	108,935	11,155	1,289	121,379		121,379		121,379			11
12	Social Services	107,886	7,887	1,289	117,062		117,062	(6,701)	110,361			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,141,844	81,979	19,253	2,243,076		2,243,076	(19,945)	2,223,131			16
	<b>C. General Administration</b>											
17	Administrative	91,354	163		91,517		91,517	(9,702)	81,815			17
18	Directors Fees											18
19	Professional Services			76,573	76,573		76,573	(6,834)	69,739			19
20	Dues, Fees, Subscriptions & Promotions			46,240	46,240		46,240	(29,785)	16,455			20
21	Clerical & General Office Expenses	69,601	23,743	105,200	198,544		198,544	(39,696)	158,848			21
22	Employee Benefits & Payroll Taxes			573,154	573,154		573,154	(8,556)	564,598			22
23	Inservice Training & Education											23
24	Travel and Seminar			46,850	46,850		46,850	(12,720)	34,130			24
25	Other Admin. Staff Transportation			11,308	11,308		11,308	(1,410)	9,898			25
26	Insurance-Prop.Liab.Malpractice			166,993	166,993		166,993	(2,110)	164,883			26
27	Other (specify):*	141,055	3,197	22,263	166,515		166,515	(166,515)				27
28	<b>TOTAL General Administration</b>	302,010	27,103	1,048,581	1,377,694		1,377,694	(277,328)	1,100,366			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,097,721	481,543	1,466,674	5,045,938		5,045,938	(627,528)	4,418,410			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number      The United Methodist Village      #0014506      Report Period Beginning:      01/01/05      Ending:      12/31/05

**V. COST CENTER EXPENSES (continued)**

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			800,000	800,000		800,000	(513,553)	286,447			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,313	1,313		1,313	(1,313)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,419	15,419		15,419		15,419			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			816,732	816,732		816,732	(514,866)	301,866			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		222,084	320,883	542,967		542,967		542,967			39
40	Barber and Beauty Shops	27,703	140	1,420	29,263		29,263	(26,951)	2,312			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,337	90,337		90,337		90,337			42
43	Other (specify):*	45,475			45,475		45,475	(45,475)				43
44	<b>TOTAL Special Cost Centers</b>	73,178	222,224	412,640	708,042		708,042	(72,426)	635,616			44
	<b>GRAND TOTAL COST</b>											
45	(sum of lines 29, 37 & 44)	3,170,899	703,767	2,696,046	6,570,712		6,570,712	(1,214,821)	5,355,891			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(39,147)	02		4
5	Telephone, TV & Radio in Resident Rooms	(21,780)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(335,303)	30		9
10	Interest and Other Investment Income	(1,313)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(493)	21		24
25	Fund Raising, Advertising and Promotional	(29,628)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(787,156)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,214,821)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (1,214,821)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
The United Methodist Village			
ID# 0014596			
Report Period Beginning:	01/01/05		
Ending:	12/31/05		
Sch. V Line			
NON-ALLOWABLE EXPENSES			
	Amount	Reference	
1 Utility Income	\$ (122,289)	08	1
2 Transportation Reimbursement	1,024	25	2
3 Child Care Salaries	(138,156)	27	3
4 Employee Benefits - Child Care	(20,927)	27	4
5 Mch-Kim	183	10	5
6 Child Care Supplies	(3,197)	27	6
7 Child Care Meals	(7,070)	02	7
8 Mch-Kim Food Expense	(20,018)	02	8
9 Blank Charges	(3,986)	21	9
10 Late Fees	(906)	21	10
11 Child Care	(1,336)	27	11
12 Accrual - Fundraising Expense	(21,391)	21	12
13 Resident Services	(6,224)	12	13
14 Resident Insurance	(597)	26	14
15 Doctor Expense	(1,490)	10	15
16 Hospital Expense	(11,917)	10	16
17 Barber and Beauty	(26,954)	40	17
18 Misc Income	(2,059)	21	18
19 Insurance Reimbursements	(1,481)	26	19
20 Non-Allowable Legal Fees	(975)	19	20
21 Transfer of Legal Fees to Lawrenceville Manor	(5,824)	19	21
22 Child Care Holiday	(2,899)	27	22
23 Marketing Salaries	(17,223)	43	23
24 Independent Living Allocation			24
25 Maintenance	(22,448)	06	25
26 Housekeeping	(15,084)	03	26
27 Dietary	(15,972)	03	27
28 Utilities	(65,409)	08	28
29 Social Services	(475)	12	29
30 Administrative	(9,466)	17	30
31 Professional Fees	(38)	19	31
32 Dues	(157)	20	32
33 Office	(16,571)	21	33
34 Employee Benefits	(8,556)	22	34
35 Insurance	(30)	26	35
36 Depreciation	(178,266)	36	36
37 Maintenance - Bonus	(390)	06	37
38 Housekeeping - Bonus	(773)	03	38
39 Dietary - Bonus	(324)	03	39
40 Administrative - Bonus	(236)	17	40
41 Office - Bonus	(290)	21	41
42 Non-Allowable Travel	(389)	25	42
43 Non-Allowable Seminar	(13,738)	24	43
44 Marketing Salaries	(28,252)	43	44
45			45
46			46
47			47
48			48
49			49
50			50
51			51
52			52
53			53
54			54
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89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(787,158)		101

## Summary A

**12/31/05**

[illegible]





VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Lawrenceville Manor	Lawrenceville			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

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1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT









**Ending: 12/31/05**

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**





**Ending: 12/31/05**

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**

## VIII. ALLOCATION OF INDIRECT COSTS

**Name of Related Organization** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City / State / Zip Code** \_\_\_\_\_  
**Phone Number** ( ) \_\_\_\_\_  
**Fax Number** ( ) \_\_\_\_\_

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25



## VIII. ALLOCATION OF INDIRECT COSTS

**Name of Related Organization** \_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**City / State / Zip Code** \_\_\_\_\_  
**Phone Number** ( ) \_\_\_\_\_  
**Fax Number** ( ) \_\_\_\_\_

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Municipal Bonds		X				\$		\$ 45,048			\$	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Old National Bank		X									1,313	6
7													7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$		\$ 45,048			\$ 1,313	9
	B. Non-Facility Related*												
10	Interest Income											(1,313)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$		\$			\$ (1,313)	14
15	TOTALS (line 9+line14)						\$		\$ 45,048			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ N/A      Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND    \$                      For                      Tax Year.    (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000		8	
		2001		9	
		2002		10	
		2003		11	
		2004		12	
<u>N/A</u>					
				13	FROM R. E. TAX STATEMENT FOR 2004    \$    13
				14	PLUS APPEAL COST FROM LINE 5    \$    14
				15	LESS REFUND FROM LINE 6    \$    15
				16	AMOUNT TO USE FOR RATE CALCULATION \$    16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT



IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The United Methodist Village COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0014506

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

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FACILITY NAME The United Methodist Village COUNTY Lawrence

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A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,538 B. General Construction Type: Exterior Brick Frame Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).  
Independent Living

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO  
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:  
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	631,620	1924	\$ 96,018	1
2		572,380	1987-89	63,690	2
3	TOTALS	1,204,000		\$ 159,708	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1965	1965	\$ 1,350,000	\$		\$	\$	\$	4
5			1967	1967	1,177,857						5
6			1974	1974	916,911						6
7			1925	1925	225,443						7
8											8
	Improvement Type**										
9	Various			1969	10,816		20			10,816	9
10	Various			1972	37,701		20			37,701	10
11	Various			1973	27,160		20			27,160	11
12	Various			1974	43,414		20			43,414	12
13	Various			1976	5,505		20			5,505	13
14	Various			1977	48,628		20			48,628	14
15	Various			1978	157,424		20			157,424	15
16	Various			1979	11,359		20			11,359	16
17	Various			1980	20,141		20			20,141	17
18	Various			1981	703,685		20			703,685	18
19	Various			1982	27,959		20			27,959	19
20	Various			1983	49,037		20			49,037	20
21	Various			1984	82,405		20			82,405	21
22	Various			1985	137,981		20			137,981	22
23	Various			1986	144,720		20	7,236	7,236	144,720	23
24	Various			1987	75,506		20	3,775	3,775	71,731	24
25	Various			1988	161,860		20	8,093	8,093	145,674	25
26	Various			1989	122,722		20	6,136	6,136	104,314	26
27	Various			1990	886,389		20	44,319	44,319	709,111	27
28	Various			1991	189,373		20	9,469	9,469	142,030	28
29	Various			1992	434,747		20	21,737	21,737	304,323	29
30	Various			1993	281,258		20	14,063	14,063	182,818	30
31	Various			1994	79,040		20	3,952	3,952	47,424	31
32	Various			1995	241,445		20	12,072	12,072	132,795	32
33	Various			1996	287,583		20	14,379	14,379	143,792	33
34	Various			1997	117,877		20	5,894	5,894	53,045	34
35	Various			1998	47,741		20	2,387	2,387	19,096	35
36	Various			1999	339,678		20	34,015	34,015	218,518	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2000	\$ 127,761	\$	20	\$ 3,381	\$ 3,381	\$ 20,286	37
38 Various	2001	135,670		20	6,795	6,795	33,975	38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67 Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68 Related Party Allocations (Pages 12-REP & 12A-REP)								68
69 Financial Statement Depreciation			621,750			(621,750)		69
70 TOTAL (lines 4 thru 69)		\$ 8,706,796	\$ 621,750		\$ 197,704	\$ (424,046)	\$ 3,836,865	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,706,796	\$ 621,750		\$ 197,704	\$ (424,046)	\$ 3,836,865	1
2	Electrical Work	2002	1,333		20	267	267	1,066	2
3	Electrical Work	2002	4,410		20	882	882	3,528	3
4	Electrical Work	2002	1,131		20	207	207	829	4
5	Wood Flooring	2002	2,279		20	209	209	836	5
6	Electrical Work	2002	4,432		20	665	665	2,659	6
7	Electrical Work	2002	1,558		20	234	234	935	7
8	Air Conditioners	2002	8,279		20	552	552	2,208	8
9	Air Conditioners	2002	10,292		20	686	686	2,745	9
10	Wiring Work	2002	16,353		20	954	954	3,816	10
11	Concrete Ramp	2002	2,500		20	97	97	389	11
12	Air Conditioners	2002	28,584		20	1,667	1,667	6,670	12
13	Office Remodeling	2002	4,664		20	333	333	1,333	13
14	Air Conditioner Duct Work	2002	6,840		20	342	342	1,368	14
15	Wood And Ceiling Tiles	2002	709		20	71	71	284	15
16	Office Remodeling	2002	2,247		20	75	75	300	16
17	Wiring And Circuit Panels	2002	9,048		20	189	189	754	17
18	Office Remodeling	2002	2,138		20	74	74	297	18
19	Phone System	2002	16,783		20	559	559	2,238	19
20	Phone System	2002	16,783		20	373	373	1,492	20
21	Air Conditioners	2002	5,835		20	389	389	1,556	21
22	Office Remodeling	2002	2,378		20	119	119	476	22
23	Boiler Removal	2002	14,144		20	471	471	1,886	23
24	Hvac System	2002	14,126		20	69	69	277	24
25	Nurse Call System	2003	43,045		20	2,631	2,631	7,892	25
26	Labor Hrs For Wes Resident Room Remodel	2003	1,638		20	60	60	180	26
27	Labor Hrs For W4S 1 Room Remodel	2003	1,171		20	39	39	117	27
28	Labor Hours For Break Room Hvac Upg	2003	514		20	15	15	46	28
29	Labor Hours For We Remodel	2003	632		20	84	84	253	29
30	New A/C Installed In Mckiou Bldg	2003	2,847		20	2,657	2,657	5,503	30
31	Labor Hours For Wi Remodel	2003	1,381		20	161	161	483	31
32	Phone System	2003	37,015		20	2,159	2,159	6,478	32
33	Labor Hours For Wi Remodel	2003	430		20	36	36	108	33
34	TOTAL (lines 1 thru 33)		\$ 8,972,314	\$ 621,750		\$ 215,031	\$ (406,719)	\$ 3,895,864	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,972,314	\$ 621,750		\$ 215,031	\$ (406,719)	\$ 3,895,864	1
2	Labor Hours For Wi Remodel	2003	1,003		20	67	67	201	2
3	Labor Hours For Wi Remodel	2003	1,047		20	52	52	157	3
4	Labor Hours For Wi Remodel	2003	394		20	7	7	20	4
5	Computer System For Phone System	2003	12,500		20	2,500	2,500	7,500	5
6	Phone System	2003	13,614		20	908	908	2,723	6
7	Dycus Auto Door	2003	215		20	21	21	64	7
8	Dycus Auto Door	2003	1,073		20	140	140	421	8
9	Carpet	2003	2,205		20	257	257	772	9
10	Flooring For Remodel	2003	2,959		20	99	99	296	10
11	Flooring For Dycus Center	2003	3,448		20	86	86	259	11
12	Corner Guard For Dycus Rooms	2003	505		20	17	17	50	12
13	Fire Alarm System	2003	35,950		20	1,798	1,798	5,393	13
14	Locks, Keypads	2004	2,492		20	125	125	250	14
15	Building Supplies	2004	3,115		20	156	156	312	15
16	Nurse Call System	2004	1,476		20	74	74	148	16
17	Weatherproof Horn Strobe	2004	782		20	39	39	78	17
18	Smoke Detectors	2004	2,114		20	106	106	212	18
19	Elevator Floor Lockout	2004	550		20	28	28	56	19
20	Furnace	2004	2,620		20	131	131	262	20
21	Smoke Detectors	2005	807		20	40	40	40	21
22	Parking Lot Repairs	2005	7,283		20	364	364	364	22
23	Handrails	2005	483		20	24	24	24	23
24	Water Heater	2005	4,389		20	219	219	219	24
25	Carpeting	2005	1,225		20	61	61	61	25
26	Door Replacement	2005	2,499		20	125	125	125	26
27	Heating And Cooling Unit	2005	1,930		20	97	97	97	27
28	Compressor	2005	2,331		20	117	117	117	28
29	Alarm Keypad	2005	1,661		20	83	83	83	29
30	Carpeting	2005	893		20	45	45	45	30
31	Flooring	2005	971		20	49	49	49	31
32	Carpeting	2005	2,732		20	137	137	137	32
33	Ceramic Tile Work	2005	4,903		20	245	245	245	33
34	TOTAL (lines 1 thru 33)		\$ 9,092,483	\$ 621,750		\$ 223,246	\$ (398,504)	\$ 3,916,641	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,092,483	\$ 621,750		\$ 223,246	\$ (398,504)	\$ 3,916,641	1
2	Fire Alarm	2005	2,351		20	118	118	118	2
3	Wall Cabinets	2005	1,320		20	66	66	66	3
4	Entrance Door	2005	1,865		20	93	93	93	4
5	Therapy Remodel Project	2005	272		20	14	14	14	5
6	Carpeting	2005	1,064		20	53	53	53	6
7	Trusses	2005	518		20	26	26	26	7
8	Sidewalk And Ramp	2005	5,000		20	250	250	250	8
9	Sidewalk And Ramp	2005	6,000		20	300	300	300	9
10	Roof And Insulation Work	2005	76,950		20	3,848	3,848	3,848	10
11	Flooring	2005	2,419		20	121	121	121	11
12	Capitalized Labor	2005	7,382		20	369	369	369	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,197,624	\$ 621,750		\$ 228,503	\$ (393,247)	\$ 3,921,898	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 365,324	\$	\$ 25,208	\$ 25,208	10	\$ 89,785	71
72	Current Year Purchases	49,706		4,971	4,971	10	4,971	72
73	Fully Depreciated Assets	2,713,887				10	2,713,887	73
74								74
75	TOTALS	\$ 3,128,917	\$	\$ 30,179	\$ 30,179		\$ 2,808,642	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		PATIENT TRANS 1999 & PRIOI	1999	\$ 152,692	\$	\$	\$	5	\$ 152,692	76
77		2001 MINI VAN	2001	26,434		5,286	5,286	5	26,434	77
78		2002 Pickup Truck	2002	27,158		2,803	2,803	5	11,212	78
79		SEE ATTACHED	2004	118,711		19,676	19,676	5	40,603	79
80	TOTALS			\$ 324,995	\$	\$ 27,765	\$ 27,765		\$ 230,942	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,811,244	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 621,750	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,447	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (335,303)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,961,482	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SEE ATTACHED - VARIOUS YEARS	\$ 5,659,260	\$ 176,765	\$ 2,759,734	86
87	REMOVED HOUSE ON 16TH STREET	4,499	600	1,800	87
88	DAY CARE - 2005	22,743	885	885	88
89					89
90					90
91	TOTALS	\$ 5,686,502	\$ 178,250	\$ 2,762,419	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 
- 

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- 
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 15,419
- Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM	IN-HOUSE PROGRAM
		IN OTHER FACILITY	IN OTHER FACILITY
		COMMUNITY COLLEGE	HOURS PER CNA
		HOURS PER CNA	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 94,906	\$		\$ 94,906	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			56,499			56,499	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			169,478			169,478	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				101,459		101,459	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						120,625		120,625	13
14	TOTAL			\$		\$ 320,883	\$ 222,084		\$ 542,967	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.				
		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,693	\$	1
2	Cash-Patient Deposits	46,241		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	707,729		3
4	Supply Inventory (priced at )	27,350		4
5	Short-Term Investments	21,801		5
6	Prepaid Insurance	53,658		6
7	Other Prepaid Expenses	81,119		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	365,317		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,304,908	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,611,186		12
13	Land	159,708		13
14	Buildings, at Historical Cost	12,779,739		14
15	Leasehold Improvements, at Historical Cost	1,356,548		15
16	Equipment, at Historical Cost	4,064,660		16
17	Accumulated Depreciation (book methods)	(12,159,366)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	448,479		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,260,954	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,565,862	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 906,446	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	278,363		28
29	Short-Term Notes Payable	45,048		29
30	Accrued Salaries Payable	345,102		30
31	Accrued Taxes Payable (excluding real estate taxes)	(22,701)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	221,659		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	(69,951)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,703,966	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,703,966	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,861,896	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,565,862	\$	48



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,770,862	1
2	Restatements (describe):		2
3	See Attached	(1,123,883)	3
4	Lawrenceville Manor Equity Transfer	(105,510)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,541,469	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,320,427	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,320,427	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,861,896	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,573,811	1
2	Discounts and Allowances for all Levels	(1,692,753)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,881,058	3
	<b>B. Ancillary Revenue</b>		
4	Day Care	95,439	4
5	Other Care for Outpatients		5
6	Therapy	900,609	6
7	Oxygen	46,145	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,042,193	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,951	13
14	Non-Patient Meals	46,217	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	329,000	16
17	Sale of Drugs	72,573	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,793	19
20	Radiology and X-Ray		20
21	Other Medical Services	340,089	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 836,623	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	1,689,816	24
25	Interest and Other Investment Income***	307,320	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,997,136	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	134,129	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 134,129	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,891,139	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,425,168	31
32	Health Care	2,243,076	32
33	General Administration	1,377,694	33
	<b>B. Capital Expense</b>		
34	Ownership	816,732	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	617,705	35
36	Provider Participation Fee	90,337	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,570,712	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,320,427	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,320,427	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,082	1,178	\$ 44,017	\$ 37.37	1
2	Assistant Director of Nursing	1,143	1,280	27,696	21.64	2
3	Registered Nurses	23,242	24,225	381,782	15.76	3
4	Licensed Practical Nurses	23,965	26,115	392,243	15.02	4
5	CNAs & Orderlies	94,373	100,394	862,152	8.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,779	9,929	94,623	9.53	8
9	Activity Director					9
10	Activity Assistants	13,284	14,315	108,935	7.61	10
11	Social Service Workers	10,109	10,986	107,886	9.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,558	38,611	290,320	7.52	15
16	Dishwashers					16
17	Maintenance Workers	11,278	12,211	138,715	11.36	17
18	Housekeepers	21,826	23,157	179,463	7.75	18
19	Laundry	6,246	6,894	45,369	6.58	19
20	Administrator	2,057	2,236	91,354	40.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,185	8,945	69,601	7.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	17,469	18,506	122,510	6.62	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	13,866	15,176	214,233	14.12	33
34	TOTAL (lines 1 - 33)	293,462	314,158	\$ 3,170,899 *	\$ 10.09	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	1,460	\$ 11,993	01-03	35
36	Medical Director	Monthly	3,300	09-03	36
37	Medical Records Consultant	Monthly	2,105	10-03	37
38	Nurse Consultant	Monthly	9,600	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	22	907	10a-03	40
41	Occupational Therapy Consultant	7	763	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,289	11-03	44
45	Social Service Consultant	48	1,289	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,586	\$ 31,246		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

N/A
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 8,272

Line 10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 90,337

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

Yes

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b.

Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

N/A

d.

Have vehicle usage logs been maintained?

No

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17)

Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Frost, Ruttenberg & Rothblatt, PC

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

No

If no, please explain.

Not Complete

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT